THE RELATIVE BENEFITS AND COSTS TO HUMAN SERVICE ORGANIZATIONS OF STAFF PARTICIPATION IN ORGANIZATIONAL DECISION-MAKING

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Problem Statement

There is considerable literature advocating participatory forms of decision-making in human service organizations (see, for example, Cherniss, 1980; Fallon, 1974; McNeely, 1983; Pines & Aronson, 1981; Price & Mueller, 1981; Resnick & Patti, 1980). Proponents regard staff participation in organizational decision-making as a critical means of: (1) providing organization leaders with adequate data for informed decisions; (2) increasing an organization's access to staff expertise, skill, creativity, initiative, and judgment; (3) increasing staff motivation and their commitment to organization decisions; (4) increasing productivity and the quality of services provided; (5) increasing staff morale and job satisfaction; and (6) reducing job stress, burnout, and staff turnover.

Not everyone is convinced that greater staff participation in organizational decision-making is desirable. Some critics suggest that staff participation may produce instability, role confusion, and interpersonal tension (Stein, 1970), or may increase stress by reducing autonomy (Pines & Aronson, 1981). Other critics simply maintain that although staff participation is helpful, other factors are more important in increasing staff motivation and job satisfaction (Raskin, 1973).

There is relatively little empirical research demonstrating the effects of participatory management practices in human service organizations. There is even less research documenting the extent to which participatory decision-making is practiced in social service or health care settings, or attempting to determine which models of participation are most effective in specific settings.

The limited studies that do exist report positive benefits for both the staff and the organization (see, for example, Brown, Finkelstein, & Miller, 1979; Cherniss, 1980; Fizdale, 1974; Hage & Aiken, 1967; McNeely, 1983; Price & Mueller, 1981; Steiner, 1977). The benefits cited are primarily related to increased job satisfaction and improved communication, but they also include greater role clarity,

decreased turnover, more innovation, and more effective performance. In at least one instance, however, participation was associated with higher costs as well as better working conditions and lower staff-client ratios (Maslach & Pines, 1977). It is difficult to generalize the findings of the research: the units studied range from the small group to the total organization, and the participatory systems described vary as to the staff included, the decision areas involved, and the extent and type of influence wielded.

Research Questions

This study examined the relationship between level of staff participation in organizational decision-making and the relative organizational health of fifteen private non-profit human service agencies. Specifically, the study sought to determine whether higher levels of staff participation are associated with higher ratings on five broad aspects of organizational health: human resources, fiscal resources, goal performance, efficiency, and responsiveness.

Although the literature provides more theoretical and empirical evidence for positive relationships between participation and some elements of organizational health than others, in order to examine the extent to which staff participation in organizational decision-making contributes to overall organizational health, this study hypothesized favorable relationships between staff participation and all the indicators of organizational health examined. The following hypotheses were tested:

1. The higher the level of staff participation in organizational decision-making, the sounder the human resource base of the agency, that is:
   a. the lower the level of voluntary staff turnover in general, and of turnover due to dissatisfaction with agency policies in particular;
   b. the lower the level of staff absenteeism and tardiness;
   c. the higher the level of staff job satisfaction;
   d. the higher the level of staff morale;
   e. the lower the level of staff stress and ill health;
   f. the higher the level of board involvement;
   g. the higher the level of board role satisfaction;
   h. the higher the level of administrative performance; and

i. the higher the level of executive director job satisfaction.

2. The higher the level of staff participation in organizational decision-making, the sounder the fiscal resource base of the agency, that is:
   a. the greater an agency's income and assets compared to other agency's of a similar size; and
   b. the greater the number of funding sources.
3. The higher the level of staff participation in organizational decision-making, the greater the level of organizational goal performance, that is:
   a. the greater the quantity, variety, and adequacy of services rendered; and
   b. the higher the quality of services rendered.
4. The higher the level of staff participation in organizational decision-making, the more efficient the agency's goal performance, that is:
   a. the higher the client/staff ratio;
   b. the lower the costs per client; and
   c. the lower an agency's overhead costs.
5. The higher the level of staff participation in organizational decision-making, the more responsive the agency to changes in its environment, that is:
   a. the greater the number of program changes; and
   b. the higher the level of community support.

Methodology

Research Design

The preferred research design for a study of the effect on organizational health of staff participation in organizational decision-making would be an experimental design varying the levels of participation for comparable organizations while controlling environmental conditions (Cook and Campbell, 1979; Poister, 1978). The realities of organizational life precluded such intervention. Instead this study examined the relationship between staff participation and organizational health by gathering cross-sectional data on fifteen private non-profit human service organizations and controlling statistically for the effect of intervening variables.

Setting and Sample

The agencies studied are all affiliates of the Southern Region of the Planned Parenthood Federation of America (PPFA). All provide a similar mix of medical, educational, and counseling services related to reproductive health and family planning, although the range and quantity of services delivered varies. Sister organizations were selected in order to reduce the effects of major intervening variables: the possibility that the nature of the services delivered, and/or the organizational structure of the agencies studied, would have an obscuring effect on the relationship between staff participation and organizational health. For the same reasons, plus the desire to control for extraneous annual fluctuations, affiliates were dropped from the potential sample if they had not been providing medical services for at least three years prior to the study. As organizational size is likely to influence individual opportunity to participate in organizational decisions, a proportional stratified random sample of large, medium, and small affiliates was selected. The final sample consisted of two large (50 or more paid staff), eight medium (16 to 49 paid staff), and five small (15 or fewer paid staff) affiliates.

Operational Definition of Variables and Data Collection

All staff, paid and volunteer, full-time and part-time, were asked to indicate their level of participation in thirty-one organizational decisions. The decisions involved hiring and evaluation of personnel, formulation and revision of organizational structure and personnel policies, design of management and client record-keeping systems, location and design of facilities, and determination of program policies and budgets. Level of participation was measured on the following scale:

1=no advance information before the decision was implemented
2=advance information before implementation, but after the decision was made
3=opportunity to comment before decision was made, but little or no influence on the decision
4=opinion solicited and had some influence on the decision
5=a vote in electing a co-worker to participate in the formal decision-making process
6=a formal vote or voice in the decision
7=complete control or veto power over the decision.

Respondents rated only those decisions that had been made during their tenure with their affiliate.

Multiple measures of the five broad aspects of organizational health were collected for each affiliate for the years 1981 to 1983. The National Office of Planned Parent-

hood provided data on type and number of services delivered, unduplicated annual patient counts, and staffing patterns from Affiliate Annual Service Reports. Data on finances and performance indicators were compiled at the Southern Region Office from Affiliate Performance Reports and Annual Financial Reports. The affiliates compiled data on service expansion and/or reduction, staff turnover, reasons for staff departures, grievances, and law suits.

The survey instruments completed by staff provided data on absences and tardiness, job satisfaction (scale derived from Quinn and Staines, 1979, and Price, 1977), stress levels (scale derived from Quinn and Staines, 1979, and Cherniss, 1980), and staff ratings of the adequacy and quality of their affiliate's programs. Survey instruments completed by board members provided data on role satisfaction, level of knowledge about their affiliate, level of involvement in affiliate activities, and board members' ratings of the adequacy and quality of their affiliate's programs. Survey instruments completed by executive directors provided data on job satisfaction and directors' ratings of the adequacy and quality of their affiliate's programs. The survey response rate was 100% for executive directors, 74.3% for board members, 58.0% for paid staff, and 38.5% for volunteers.

Data Analysis

Several measures of staff participation in organizational decision-making were calculated. Average level of participation was determined by calculating the mean of the individual's scores on the decisions rated. Total amount of influence was determined by calculating the sum of the individual's scores on the decisions rated. Affiliate scores were calculated by aggregating staff scores. This was done for all staff surveyed and for paid staff only.

Similarly, affiliate scores for organizational health variables, such as staff job satisfaction, staff stress level, adequacy of services offered, quality of services rendered, board involvement in affiliate activities, board knowledge level about their affiliate, and board satisfaction were calculated by aggregating the appropriate staff or board scores.

Correlations between participation variables and organizational health variables were tested for strength of association and statistical significance. Where appropriate, partial correlations controlling for affiliate size and decentralization were also tested. To limit the length and complexity of the discussion of the results of the study, only the statistical analysis for average level of

paid staff participation will be reported, and partial correlations will be reported only when controlling for affiliate size and/or decentralization makes a statistically significant difference in the main relationship in question.

Results

Characteristics of the Sample

The fifteen affiliates surveyed ranged in age from 6 to 48 years. Three served primarily urban areas, and the rest served a mixed urban and rural area. Number of clinic locations ranged from one to nine ($\bar{x}$=3), scheduled clinic hours from 9 to 240 per week ($\bar{x}$=81), and unduplicated annual patient counts from 486 to 47,393 ($\bar{x}$=9521). Annual income for 1983 ranged from $103,100 to $2,801,500 ($\bar{x}$=$725,687). Number of board members ranged from 18 to 50 ($\bar{x}$=30), paid full-time staff from 4 to 87 ($\bar{x}$=20), paid part-time staff from 2 to 30 ($\bar{x}$=13), and volunteer staff from 4 to 75 ($\bar{x}$=26).

Level of Participation

Affiliate scores for average level of paid staff participation were calculated for each decision and for eight clusters of decision-making areas, as well as for overall organizational decision-making. Table 1 provides a breakdown of mean affiliate scores for paid staff participation in the eight decision clusters and in overall organizational decision-making.

Table 1
Average Level of Paid Staff Participation in Eight Clusters of Decision-Making Activities

Decision Area	Affiliate Scores	
	Mean	S.D.
Designing Facilities	4.03	1.06
Revising Record-keeping Systems	3.66	0.75
Revising Administrative Structure	3.44	0.85
Program Planning	3.41	0.61
Evaluating Personnel	3.38	0.41
Hiring Personnel	3.28	0.62
Revising Personnel Policies	2.91	1.03
Determining Finances	2.64	0.75
Overall Organizational Decisions	3.32	0.40

Key: 1=no advance information
2=advance information
3=comment but no influence
4=some influence
5=representative voice/vote
6=personal voice/vote
7=complete control/veto power

Relationship Between Participation and Organizational Health

Table 2 breaks down the relationship between average level of paid staff participation and measures of the health of human resources.

Table 2
Relationship Between Average Level of Paid Staff Participation and Health of Human Resources

Indicator of Health of Human Resources	Correlation With Average Paid Staff Participation	
	r	p
Staff Turnover		
Average Rate 1981-83	ns	
Average Voluntary Rate 1981-83	ns	
Average Voluntary Rate due to Dissatisfaction 1981-83	-.44	<.05
% Currently Seeking Employment Elsewhere	ns	
% Planning to Leave Within 12 Months	ns	

Table 2 Continued
Relationship Between Average Level of Paid Staff Participation and Health of Human Resources

Indicator of Health of Human Resources	Correlation With Average Paid Staff Participation r	p
Staff Absenteeism/Tardiness		
Tardiness	ns	
Absenteeism	ns	
Absenteeism not due to Illness	ns	
Staff Job Satisfaction		
Intrinsic	.70	<.01
Extrinsic	.57	<.01
Overall	.68	<.01
Staff Satisfaction with PP		
With Role	.51	<.05
With Affiliate	.68	<.01
With PPFA	ns	
Overall	.63	<.01
Grievances/Law Suits Filed Against Affiliate by Staff 1981-83		
Grievances	ns	
Law Suits	ns	
Staff Morale		
Staff Assessment	.53	<.05
Board Assessment	.54	<.05
E.D. Assessment	ns	
C:s/d	.49	<.05
Staff Stress Level	-.59	<.01
Board Support and Involvement		
Staff Assessment	ns	
Board Assessment	ns	
E.D. Assessment	ns	
% of Board Members Contributing Annually to Affiliate	ns	
% of Board Members Contributing Annually to PPFA	ns	
Board Activity Level	ns	
% of Board Members Lacking Adequate Information about Their Affiliate	-.47	<.05

Table 2 Continued
Relationship Between Average Level of Paid Staff Participation and Health of Human Resources

Indicator of Health of Human Resources	Correlation With Average Paid Staff Participation r	p
Board Satisfaction with PP		
With Role	ns	
C:s/d	.52	<.05
With Affiliate	ns	
With PPFA	ns	
Overall	ns	
Administrative Quality		
Staff Assessment	.49	<.05
Board Assessment	ns	
E.D. Assessment	ns	
% of Board Members Lacking Adequate Information about Their Affiliate	-.47	<.05
% of Staff Having Uncommunicated Program Information	ns	
E.D. Satisfaction with PP		
With role	ns	
C:s/d	.52	<.05
With affiliate	ns	
With PPFA	ns	
Overall	ns	
C:s/d	.47	<.05

Key: C:s/d=Controlling for organizational size and decentralization

Level of staff participation in overall organizational decision-making was favorably associated with many human resource measures, especially with greater role satisfaction of staff and more favorable assessments of staff morale. Greater staff participation was also associated with lower staff turnover due to dissatisfaction with affiliate policies or practices; lower staff stress levels; more informed board members; and more favorable staff assessments of administrative performance. When size and decentralization of the organization were statistically controlled, affiliates with higher levels of staff participation received higher role satisfaction ratings from board members and executive directors.

Table 3 breaks down the relationship between average level of paid staff participation and measures of the health of fiscal resources.

Table 3
Relationship Between Average Level of Paid Staff Participation and Health of Fiscal Resources

Indicator of Health of Fiscal Resources	Correlation With Average Paid Staff Participation r	p
Income and Assets		
Average income 1981-1983	ns	
Average income from three-year performance profile	ns	
C:s/d	.53	<.05
Average assets from three-year performance profile	ns	
Funding Sources		
Average # of Donors 1981-83	ns	
Average # of Income Sources 1981-83	ns	
Average # of Income Sources from three-year performance profile	(-.68)	<.01

Key: C:s/d=Controlling for organizational size and decentralization
()=Direction of relationship opposite to that hypothesized

Level of staff participation correlated positively with affiliate income and negatively with variety of funding sources.

Table 4 breaks down the relationship between average level of paid staff participation and measures of goal performance.

Table 4
Relationship Between Average Level of Paid Staff Participation and Organizational Goal Performance

Indicator of Organizational Goal Performance	Correlation With Average Paid Staff Participation r	p
Quantity of Services Delivered		
Average annual patient volume from three-year performance profile	ns	
Average annual patient volume 1981-1983	ns	
Average clinic hours per wk 1981-83	ns	
Average annual # of education sessions conducted 1981-83	ns	
Variety of Services Offered 1982	ns	
Adequacy of Services Offered		
Staff assessment	ns	
Board assessment	ns	
E.D. Assessment	ns	
Program Quality		
Staff assessment	.43	<.05
Board assessment	ns	
E.D. assessment	ns	
Client satisfaction		
Staff assessment	.45	<.05
Board assessment	ns	
E.D. assessment	.60	<.01

Level of staff participation was not significantly related to patient volume or number of educational services rendered. It was positively related to staff assessments of program quality and client satisfaction, as well as to executive director assessments of client satisfaction.

Table 5 breaks down the relationship between average level of paid staff participation and measures of efficiency.

Table 5
Relationship Between Average Level of Paid Staff Participation and Organizational Efficiency

Indicator of Organizational Efficiency	Correlation With Average Paid Staff Participation r	p
Client/Staff Ratio		
Average Patient/Staff Ratio 1981-83	(-.61)	<.01
Average Patient/Paid Staff Ratio 1981-83	(-.57)	<.05
Cost Per Patient		
Average Patient Services Expenses Per Patient 1983	(.65)	<.05
Average Affiliate Expenses Per Patient 1981-83	(.58)	<.05
Overhead Costs		
Average Ratio of Management Expenses to Total Expenses 1981-83	ns	
Average Return on Fundraising Dollar	ns	

Key: ()=Direction of relationship opposite to that hypothesized

Affiliates with higher levels of staff participation had lower client/staff ratios and higher costs per client. There were, however, no statistically significant differences in overhead costs such as management expenses.

Table 6 breaks down the relationship between average level of paid staff participation and measures of organizational responsiveness.

Table 6
Relationship Between Average Level of Paid Staff Participation and Organizational Responsiveness

Indicator of Organizational Responsiveness	Correlation With Average Paid Staff Participation r	p
Program Change		
# Program Changes since 1/81	.58	<.01
Program Growth Since 1/81	ns	
Program Cuts Since 1/81	ns	
Community Support		
Staff Assessment	ns	
Board Assessment	ns	
E.D. Assessment	ns	
C:s/d	.49	<.05
Community response to affiliate 1982	ns	
Patient/Community Lawsuits against affiliate 1981-83	ns	

Affiliates with higher levels of staff participation experienced more program changes, and, again, were assessed more favorably in regard to client satisfaction.

Interpretation of the Findings

Due to the cross-sectional nature of the study design, it is not possible to say for certain whether associations between staff participaton and organizational health are the result of the effect of staff participation on the health of the organization, or the effect of organizational health on the participation of staff, or a spurious effect of some undetermined third variable upon both staff participation and organizational health. It is clear, however, that the association is strongest and most consistently favorable for soft measures of organizational health, such as staff job satisfaction and morale, board knowledge level, and client satisfaction. The results are more ambiguous with respect to hard measures: staff participation is positively related to organizational income and program changes, unrelated to patient volume, and, unfortunately for these difficult economic times, positively related to per patient costs. Thus the findings of this study support previous studies that show higher quality services to be associated with

lower client/staff ratios, and consequently higher per client costs. Higher levels of staff participation are associated with the former, quality, and consequently also with the latter, costs.

Another major limitation of the study is sample size. Although the study contacted a substantial number of individuals, much of the data analysis utilized the affiliate as the unit of observation. A sample size of fifteen is respectable in organizational studies, but it severely limits the ability of results to achieve statistical significance. In numerous instances in this study, correlations between variables were observed which exceeded .35, but were not statistically significant at the .05 level. In the great majority of cases, the direction of the correlation was supportive of the hypothesis that staff participation is associated with organizational health, but the decision rule applied prevented the introduction of both supportive and contradictory findings when they failed to achieve a .05 level of significance.

Additionally, the fact that the human services agencies studied were all Planned Parenthood affiliates may limit the generalizability of the findings. Planned Parenthood affiliates are, however, typical of many human service organizations in that they are non-profit corporations with community boards that deliver a variety of health and social services with limited resources in an often hostile environment. The findings from this study would seem to be at least as applicable, and possibly more applicable, to other human service organizations as the findings about employee participation in industry.

Implications for Social Work Practice

The findings of the study suggest that more involvement of staff in organizational decision-making would be likely to increase staff job satisfaction in agencies suffering from low morale and/or high stress. Greater staff participation may also be beneficial for agencies whose boards are less involved and knowledgeable than desired, and for agencies troubled by dissatisfied clients and/or lack of community support. More staff participation in organizational decision-making can also be helpful in improving program quality, but administrators should not expect improved services to be less costly. The support, though limited, found in the study for positive relationships between staff participation and board members' and executive directors' role satisfaction may be reassuring to administrators of human service organizations.

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